Provider *Insider*

Alabama Medicaid Bulletin **March 2007**

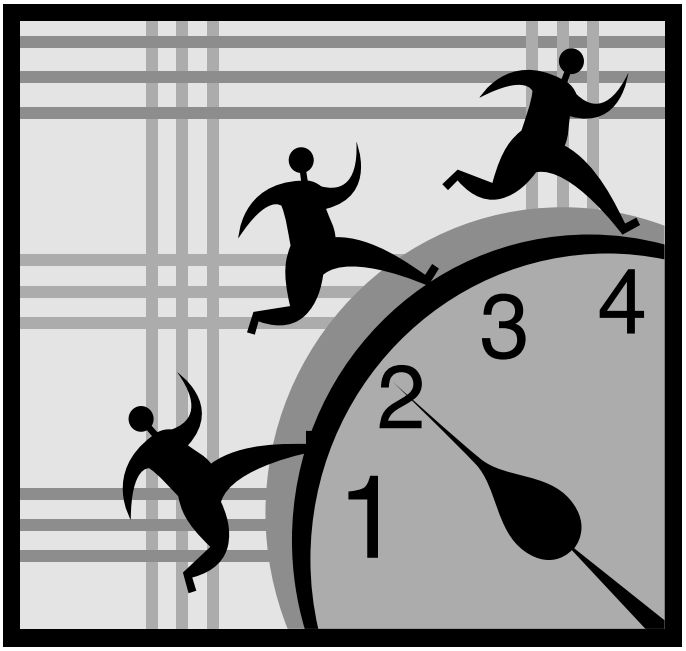
The checkwrite schedule is as follows:

03/09/07 03/23/07 04/06/07 04/20/07 05/11/07 05/25/07

As always, the release of direct deposits and checks depends on the availability of funds.

NPI Notification Deadline Date Has Passed

The March 1, 2007 deadline for submitting your NPI numbers to EDS has expired. There remains a large number of providers who have not yet submitted their numbers. All eligible Alabama Medicaid Providers should immediately submit their NPI information, including taxonomy codes, to EDS.



You should submit an NPI Notification form, which can be located on the Medicaid website at, *www.medicaid.alabama.gov/billing/NPI.aspx*, along with a copy of the notification letter received from the enumerator, to EDS. The NPI Notification form for Individual Providers should be completed to link your individual performing numbers to your individual NPI. The NPI Notification form for Organizational Providers should be completed to link your group/payee or facility provider number(s) to your group's or facility's Organizational NPI. With the exception of providers, who are sole proprietors, group practices should submit a NPI notification form to report their organizational NPI.

If you are a large group practice and will be submitting more than 25 NPI numbers, you may use the NPI Large Group Provider Spreadsheet which can be located at the site indicated above.

If you currently have a group/payee number you will need to report the organizational NPI for your group/payee number.

The form and letter or spreadsheet may be faxed to 334-215-4118 or mailed to:

EDS Provider Enrollment
P.O. Box 241685
Montgomery, AL 36124

If you have questions regarding how to fill out the NPI Notification form, contact your Provider Representative at 1-800-688-7989 (within Alabama) or (334)215-0111 (outside of Alabama).

You will continue to submit claims with your current Alabama Medicaid Provider number until the new system to accommodate NPI numbers is implemented.

In This Issue...

Pass It On!

Everyone needs to know the latest about Medicaid.

Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Dept.*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

Procedures Requiring Prior Authorization

In order to determine if a procedure requires prior authorization, reference may be made to the Physician Fee Schedule posted on Medicaid's website at *www.medicaid.alabama.gov*, the Physician Drug Fee Schedule, and/or by calling the Provider Assistance Center at 1-800-688-7989. If further assistance is needed, you may contact your EDS Provider Representative at 1-800-688-7989.

Pulse Oximetry Information

Non-invasive ear or pulse oximetry services (procedure codes 94760-94762) are considered bundled services and, therefore, are not separately reimbursable. The only time these services are separately payable are when they are medically necessary and there are no other services payable under the physician fee schedule billed on the same date by the same provider. Non-invasive ear or pulse oximetry services are subject to post-payment review and adjustment.

Medicaid Adopts the CPT Modifier 51 Exempt Policy

Effective April 1, 2007, Medicaid will adopt the CPT Modifier 51 Exempt Policy. Therefore, all CPT designated Modifier 51 Exempt procedures will not be subject to the rule of the 50 percent reduction for multiple surgeries. The other exception to the 50 percent reduction is "Add-on" codes.

EDS Not Accepting Updated CMS-1500 or UB-04 Forms

EDS is not accepting the updated CMS-1500 or UB-04 forms at this time. If claim forms are received, they will be returned to the provider without being processed. Providers will be notified when the updated forms will be accepted.

www.medicaid.alabama.gov

PMP Disenrollment from Patient 1st

The Agency has identified instances of Primary Medical Providers (PMPs) leaving their practice without notifying the Agency. This creates a hardship for recipients who are assigned to that provider and hinders their access to care. It is imperative for the Agency to be notified, through EDS, of any changes to the provider's enrollment status. Please note the following when terminating or changing the status of your Patient 1st enrollment:

The PMPs agreement to participate in the Patient 1st program may be terminated by either the PMP or Agency, with cause or by mutual consent; **upon at least 30 days' written notice** and will be effective on the first day of the month, pursuant to processing deadlines. Failure to provide a 30-day notice may preclude future participation opportunities and/or recoupment of case management fees. The PMP should also notify the Agency of any and all changes to information provided on the initial application for participation. If such changes are not reported within 30 days of change, then future participation may be limited.

A written request must be submitted by the PMP to Provider Enrollment at EDS with the effective date given. Patients will automatically be reassigned based on the following:

If a PMP is leaving a group practice, then patients will be reassigned to a practitioner within the group; or

If the remaining group practitioner does not want to assume the caseload, then patients will be assigned through the automated assignment process. For a short period of time, these patients will not be enrolled in the **Patient 1st** Program; or

If the PMP has made arrangements with another practitioner to assume his/her caseload, then these specifics will be taken into consideration. The disenrollment notification must specify such arrangements.

Additionally, the PMP must give written notice of termination of the contract, within 15 days after receipt of the termination notice by Medicaid, to each enrollee who received his or her primary care from, or was seen on a regular basis.

If you have questions about the above requirements contact Paige Clark, R.N. at (334) 242-5148. To contact EDS Provider Enrollment call 1-800-362-1504.

Clarification on Billing Interperiodic EPSDT Screening

Reimbursement for EPSDT Interperiodic screenings has not changed. The Evaluation and Management code level of care chosen must be supported by medical record documentation. It is **very important** to append the **EP modifier** when filing for an Interperiodic screening, as these screenings will not count against benefit limits. Refer to the Alabama Medicaid Provider Manual Chapter 28 for policy concerning filing office visits, inpatient visits and EPSDT screenings on the same date of service by the same provider or provider group. If further information is needed, concerning Interperiodic screenings, please refer to Appendix A.

NOTE: Interperiodic screenings must always be filed with the patient's other insurance first. Claims may be filed with the appropriate office visit or subsequent inpatient visit to the other insurance. Once the claim has been paid/denied from the other insurance, Medicaid may then be billed for the Interperiodic screening **(with an EP modifier)**. Please refer to Chapter 5, Filing Claims, for information concerning third party billing instructions.

Attention VFC Providers

Effective 11/1/06, the Human Papilloma Virus (HPV) vaccine was covered through the VFC Program. The HPV vaccine is covered for children 9 years of age through 18 years of age. Procedure code 90649 must be used when billing Medicaid for the administration of this vaccine.

NOTE: The Alabama Department of Public Health, VFC Program, has corrected their order forms to reflect the above age group. Please share this information with your billing staff. For more information concerning the HPV vaccine, please contact the VFC Program at 1-800-469-4599.

Hyaluronan (Sodium Hyaluronate) or Derivative for Intra-Articular Injection

The 2007 HCPCS code for Hyaluronan (sodium hyaluronate) has been changed to J7319. The previous HCPCS codes, J7317 and J7320 have been deleted. There is a misprint in the HCPCS Appendix 1 reference to the drug Orthovisc for J7318. Procedure Code J7318 is not a valid code as verified by Ingenix (HCPCS).

Attention Hospice Providers

All Medicaid hospice providers must use the revised Form 165B, the Hospice Recipient Status Change Form, beginning February 1, 2007. The revised form contains a confidentiality warning at the bottom of the document and is available on the Alabama Medicaid Agency website at *www.medicaid.alabama.gov*.

DME Provider Information

Effective January 1, 2007, procedure codes E0164 (commode chair, mobile with fixed arms) and E0166 (commode chair, mobile with detachable arms) were deleted. Procedure codes E0164 and E0166 were replaced with procedure code E0165 (commode chair, mobile or stationary, with detachable arms).

Effective January 1, 2007, procedure code E0180 (pressure pad alternating with pump) was deleted. Procedure code E0180 was replaced with procedure code E0181. The description for procedure code E0181 has been updated to reflect powered pressure reducing mattress overlay/pad, alternating with pump, includes heavy duty.

Effective January 1, 2007, procedure code E2320 (power wheelchair accessory, hand or chin control interface, remote joystick or touchpad, proportional, including all related electronics, and fixed mounting hardware) was deleted. It was replaced with procedure codes E2373 (power wheelchair accessory, hand or chin control interface, mini-proportional, compact, or short throw remote joystick or touchpad, proportional, including all related electronics and fixed mounting hardware) and E2374 (power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only).

Dental Policy Clarifications

Alabama Medicaid would like to clarify the policy limitations on the new CDT2007 codes implemented effective January 1, 2007.

D0145 Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver

This code is intended to be for the first visit to a dental office for a patient under three (3) years of age, for evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling with the child's parent or guardian. The code will only be allowed once per recipient lifetime and cannot be billed on the same date of service as procedure codes D0120 (periodic exam); D0140 (limited oral evaluation) or D0150 (comprehensive oral evaluation).

D1206 Topical Fluoride Varnish, Therapeutic Evaluation for Moderate to High Risk Caries

In order to bill this code the patient must have documented evidence of moderate to high risk caries. This procedure can only be billed once annually and is not allowed on the same date of service as D1203 (topical application of fluoride – child); D1204 (topical application of fluoride – adult); D1110 (prophylaxis – adult) or D1120 (prophylaxis – child).

If you have additional questions, please call the Dental Program at (334) 353-5533.

Procedures To Follow When Recipients Request To Change Rendering Providers for a Prior Authorized DME Procedure

1. The initial rendering provider must submit a written request to the Alabama Medicaid Agency indicating that they are aware and agree with the decision of the recipient to change providers and that the approved PA may be cancelled with the effective end date for services.
2. The new provider must submit a written request to the Alabama Medicaid Agency stating that they will now be submitting a PA on the recipient's behalf and have the patient sign that they agree and understand the change.
3. Medicaid's PA Unit will cancel the approved PA request in the system.
4. Medicaid's PA Unit will review the new provider's PA request for approval or denial.

If you have any additional questions or need further clarification, please contact Ida Gray at (334)-353-4753.

PMP Request Dismissal of Recipient

A PMP may request removal of a recipient from his panel due to good cause.* All requests for patients to be removed from a PMP's panel should be submitted in writing and provide the enrollee 30 days' notice from the first date of the month in which you are dismissing the enrollee.

*According to the guidelines listed in the 1915(b) (i) waiver of the Social Security Act which allows the operation of the Patient 1st Program, good cause is defined as:

- Behavior on the part of the recipient which is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the recipient or other affected recipients is seriously impaired,
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or
- Fraudulent use of the Medicaid card.

The PMP is responsible for sending a letter of dismissal to the enrollee and including a copy as an attachment to documentation provided to Medicaid. The dismissal letter should be addressed to the patient and signed by the PMP.

The dismissal request to Medicaid should contain recipient name, Medicaid number, address, telephone number, and the reason why the PMP does not wish to serve as the recipient's PMP.

The recipient will be given the opportunity to change the selected PMP before the active assignment date. **The original PMP must continue to provide services or make referrals for services to the recipient until such time the reassignment is complete**. All reassignments will be made effective the 1st of a month.

Dismissal requests should be mailed or faxed to the Medicaid Agency. The fax number is (334) 353-3856. If you have questions about the above requirements, contact Gloria Wright at (334) 353-5907.

EPSDT Interperiodic Screening Codes Have Changed

Effective for dates of service, January 1, 2007, and thereafter, EPSDT Interperiodic screening codes were changed. In place of procedure codes 99391-99395 (with no modifier), the following Interperiodic procedure codes must be utilized with an EP modifier:

99211EP through 99215EP – Office and/or outpatient setting

99233EP – Inpatient Setting

NOTE: The Comprehensive EPSDT screening codes 99381EP –99385EP and 99381EP–99395EP did not change.

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Alabama Medicaid Bulletin
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